



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor  
RICHARD M. ARMSTRONG – Director

LESLIE M. CLEMENT - Administrator  
DIVISION OF MEDICAID  
Post Office Box 83720  
Boise, Idaho 83720-0036  
PHONE: (208) 334-6626  
FAX: (208) 364-1888

February 20, 2008

Renee Brennan, Administrator  
Annabelle House, Assisted Living Concepts, Inc  
917 E Ustick Rd  
Caldwell, ID 83605

License #: RC-576

Dear Ms. Brennan:

On February 5, 2008, a complaint investigation survey was conducted at Annabelle House, Assisted Living Concepts, Inc. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

- Non-core issues, which are described on the Punch List, and for which you have submitted evidence of resolution.

This office is accepting your submitted evidence of resolution.

Should you have questions, please contact Sydnie Braithwaite, RN, Health Facility Surveyor, Residential Community Care Program, at (208) 334-6626.

Sincerely,

SYDNIE BRAITHWAITE, RN  
Team Leader  
Health Facility Surveyor  
Residential Community Care Program

SB/sc

c: Jamie Simpson, MBA, QMRP Supervisor, Residential Community Care Program



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February 13, 2008

Renee Brennan, Administrator  
Annabelle House, Assisted Living Concepts, Inc  
917 E Ustick Rd  
Caldwell, ID 83605

Dear Ms. Brennan:

On February 5, 2008, a complaint investigation survey was conducted at Annabelle House, Assisted Living Concepts, Inc. The facility was found to be providing a safe environment and safe, effective care to residents.

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference. The completed punch list form and accompanying evidence of resolution (e.g., receipts, pictures, policy updates, etc.) are to be submitted to this office by March 6, 2008.

Should you have any questions about our visit, please contact me at (208) 334-6626.

Sincerely,

JAMIE SIMPSON, MBA, QMRP  
Supervisor  
Residential Community Care Program

JS/sc

Enclosure



# IDAHO DEPARTMENT OF HEALTH & WELFARE

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February 13, 2008

Renee Brennan, Administrator  
Annabelle House, Assisted Living Concepts, Inc  
917 E Ustick Rd  
Caldwell, ID 83605

Dear Ms. Brennan:

On February 5, 2008, a complaint investigation survey was conducted at Annabelle House, Assisted Living Concepts, Inc. The survey was conducted by Sydnie Braithwaite, RN and Donna Henscheid, LSW. This report outlines the findings of our investigation.

## **Complaint # ID00003258**

**Allegation #1:** The facility did not conduct an initial evaluation on the identified resident until five months after admission.

**Findings:** Based on record review and interview, it was determined that an assessment had been completed by the former facility RN.

The resident's records were reviewed and documented the resident was admitted on October 6, 2006 and a nursing assessment was completed on October 11, 2006.

**Conclusion:** Unsubstantiated. Although the allegation may have occurred, it could not be determined during the complaint investigation.

**Allegation #2:** The facility did not provide a resident with meaningful activities.

**Findings:** Based on observation and interview, it could not be determined the facility was not providing a resident with meaningful activities.

On February 5, 2008 surveyors observed the activity calender which contained a full variety of activities. Further, at 2:00 p.m., the surveyors observed an activity being provided in the dining room with eight residents participating.

On February 5, 2008 eight residents were interviewed about facility activities. They all expressed satisfaction with the activity program and knew where to find the daily posted activities. Further, the residents stated that staff would provide reminders when an activity was about to take place.

On February 5, 2008 at 11:00 a.m., a former facility nurse stated that she had often observed the staff offering to take residents to activities.

On February 5, 2008 at 2:10 p.m., a caregiver stated this resident was alert and oriented and aware of the activities being provided. The caregiver further stated the resident would sometimes refuse staff offers to participate in the activities scheduled.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation.

Allegation #3: The facility was not kept in a clean, orderly manner.

Findings: Based on observation and interview, it was determined the facility had not been kept in a clean and orderly manner at the time of the complaint.

On February 5, 2008 at 9:00 a.m., a facility tour was conducted. Nine resident rooms were observed to be clean, orderly, and free of odor.

On February 5, 2008 seven residents were interviewed and four residents confirmed the facility had problems retaining housekeeping staff and that there had been problems with rooms not being cleaned.

On February 5, 2008 at 11:45 a.m., a former employee was interviewed. She stated that there was staff turnover problems during the time of the complaint and not all housekeeping duties were being completed.

On February 5, 2008 at 2:15 p.m., a caregiver was interviewed and she stated, "The facility was short-staffed during the time of the complaint and not all housekeeping tasks were being completed." Further, she stated the resident's family had complained to her about the resident's room not being cleaned; the caregiver passed this concern on to management but was unsure of management's response.

Conclusion: Substantiated. However, the facility was not cited as they had taken appropriate actions to rectify the housekeeping situation and the facility was observed to be clean and orderly at the time of the investigation.

Allegation #4: The facility did not assist the resident with her showers.

**Findings:** Based on record review and interview, it was determined the resident was to receive staff assistance with showers but did not always receive this assistance. On February 5, 2008 at 10:00 a.m., the resident's record was reviewed and documented the resident had been discharged on 09/17/07. Further, the resident's NSA (negotiated service agreement/care plan) dated 03/29/07 documented the resident was to receive staff assistance with showers twice a week.

On February 5, 2008 at 11:00 a.m., seven residents were interviewed and stated they received assistance with showers as needed or requested.

On February 5, 2008 at 12:20 p.m., the regional nurse confirmed the facility was having staffing issues at the time of the complaint. During the regional nurse's quality assurance (QA) inspection, she noted some areas of concern related to the elimination of ADL (activities of daily living) task sheets. The facility restarted the use of the ADL task sheets, staffing improved and cares were now being provided as outlined in the residents' NSAs.

On February 5, 2008 at 2:15 p.m., a caregiver confirmed staff were not always able to provide showers during the time of the complaint because they were "short-staffed." Further, the caregiver stated the resident's family had complained to her about the resident not receiving showers. The caregiver stated she told management about the family's concern but was not sure of management's response. The caregiver stated currently the residents are receiving shower assistance as outlined in their NSAs.

**Conclusion:** Substantiated. However, the facility was not cited because the problem was identified and corrected. Current residents expressed satisfaction with the ADL assistance being provided.

**Allegation #5:** The facility did not seek medical treatment for a resident in a timely manner.

**Findings:** Based on record review and interview, it was determined the facility did not seek medical treatment for a resident in a timely manner.

On February 5, 2008 resident service notes were reviewed. There was no documentation the former facility RN had addressed the resident's change of condition. A late entry made by the regional nurse for July 27, 2007 documented the resident was hospitalized for a possible bowel obstruction.

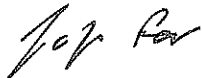
On February 5, 2008 at 12:22 p.m., the regional nurse stated the former facility RN had turned in her notice but was to remain at the facility until 5:00 p.m. on July 27, 2007. The regional nurse stated she received a phone call from facility caregivers between 4:00 p.m. and 6:00 p.m. on July 27, 2007 informing her a resident was "curled up on the bed and not feeling good." At that time the regional nurse instructed staff to call 911.

On February 5, 2008 at 2:15 p.m., a caregiver stated a resident had complained of stomach pains two to three days prior to July 27, 2007. She further stated she had informed the former facility RN but was unsure what was done with this information.

Conclusion: Substantiated. The facility was issued a non-core deficiency at IDAPA 16.03.22.305.03 for not having a nursing assessment performed when there was a change in the resident's condition. The facility was required to submit evidence of resolution within 30 days.

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,



SYDNIE BRAITHWAITE, RN  
Team Leader  
Health Facility Surveyor  
Residential Community Care Program

SB/sc

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Community Care Program  
Sydnie Braithwaite, RN, Health Facility Surveyor



Page 1 of

## ASSISTED LIVING

### Non-Core Issues

### Punch List

Facility Name	Physical Address	Phone Number
Annabelle House	917 E. Hollick Rd. Caldwell	208-455-2324
Administrator	City	ZIP Code
Pence Brennan	Caldwell	83605
Survey Team Leader	Survey Type	Survey Date
Shirley Bretherton RN	Complaint Investigation	02/05/08

**NON-CORE ISSUES**

[illegible]

Signature of Facility Representative

Date Signed \_\_\_\_\_

03/06/08

George Brannan, R.D.